

**PROBATE COURT OF FRANKLIN COUNTY, OHIO**  
**LAWRENCE A. BELSKIS, JUDGE**

IN THE MATTER OF \_\_\_\_\_

CASE NO. \_\_\_\_\_

**APPLICATION TO AUTHORIZE MEDICATION  
OR MEDICAL PROCEDURE**

[R.C. 2101.24 and R.C. 5122.271]

Pursuant to R.C. 5122.271 and/or R.C. 2101.24 the undersigned has information to believe or has actual knowledge that \_\_\_\_\_

is in need of \_\_\_\_\_ and is

\_\_\_\_\_ physically \_\_\_\_\_ mentally unable to receive information required to give fully informed,

intelligent, and knowing consent to the following procedure: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

As shown in Attachment A, the undersigned further states that said procedures are necessary to protect the general health and well-being of the above named person and asks that the Court authorize the above procedures.

The undersigned further states that this Court has jurisdiction to hear this matter pursuant to R.C. 5122.271 and/or R.C. 2101.24.

The undersigned further states that there is no guardian available to consent and attached is the opinion of the chief medical officer or attending physician and a concurring opinion by a licensed physician.

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
CONCURRING OPINION

CASE NO. \_\_\_\_\_

## ATTACHMENT A

Information necessary to provide informed consent:

1. Reason for and the nature of the proposed treatment, specifically documenting the nature, seriousness, and probable complications of the illness or disorder.  
[Describe behavior which demonstrates inability to care for oneself or other factual events showing behavior that is dangerous to self or others]
2. The probable degree and duration of expected improvement or remission with and without the proposed treatment. Give a history of compliance and response to past treatment.

CASE NO. \_\_\_\_\_

3. Describe the specific treatment regimen, including a specific medication(s) you are seeking authority to implement.

4. The nature, degree, duration, and probability of side effects and/or significant risks.

CASE NO. \_\_\_\_\_

5. A reasonable alternative treatment and reasons why the proposed treatment is recommended.

\_\_\_\_\_  
APPLICANT (CHIEF CLINICAL OFFICER  
IF APPLICATION IS FOR SURGERY) DATE

\_\_\_\_\_  
TREATING PHYSICIAN DATE